

Please fill out the following forms and either mail it or drop it off to MacColl YMCA's office

Please Note:

Please call and check for availability - enrollment is not guaranteed.

A registration fee of \$35.00 is due at time of registration
and is non-refundable

MacColl YMCA

Attn: Child Care Registration
26 Breakneck Hill Road
Lincoln, RI 02865
(401) 725-0773



MACCOLL YMCA
CHILD CARE SERVICES APPLICATION

Lincoln

Central, Lonsdale, Northern, Saylesville, Lincoln Middle School*

2011 - 2012

(Grades 1st - 8th grade)



Child's Name: _____ Male _____ Female _____

School: _____ Grade: _____

Date of Birth: _____ Age: _____

Estimated Drop Off Time: _____ / Pick-Up Time _____

Please provide us with a preferred E-Mail Address that you would like us to use to contact you:
_____ Contact Name: _____

REGISTRATION FEE OF \$35.00 IS DUE AT TIME OF REGISTRATION AND IS NON-REFUNDABLE

*Potential Savings of
\$645 - \$1050
With MacColl
Family Membership*

WEEKLY CHARGES

*MacColl YMCA
Family Membership
\$120 per year*

****Prices are Subject to Change****

		Member	Participant
_____ Early Risers Only*	7:00am- 9:00am	\$40.00	\$60.00
*(NOT AVAILABLE TO MIDDLE SCHOOL STUDENTS)			
_____ After School Only	Dismissal- 5:45pm	\$70.00	\$85.00
_____ Early Risers* & After School	7:00am- 9:00am Dismissal- 5:45pm	\$100.00	\$125.00
*(NOT AVAILABLE TO MIDDLE SCHOOL STUDENTS)			

I have received a copy of the MacColl YMCA Parent Handbook

(Parent / Guardian Signature)

_____ Start Date	_____ Medical Form	_____ Payment Form
_____ Processing Fee	_____ Staff Initials	_____ Today's Date

*All applications are updated annually. Parents must **immediately** notify the site and MacColl YMCA of any changes on the child's information sheet, and on the pick-up list.*

CHILD'S INFORMATION SHEET

Child's name: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Date of birth: _____

Child resides with: ___ Both parents ___ Mother ___ Father
___ Other (please specify) _____

Parent / Guardian information

Male: ___ Female: ___

Name: _____ Date of Birth: _____

Place of employment/ school: _____

Work number: (____) _____ ext _____ Cell/Other: (____) _____

E-Mail Address: _____

If different than child's;

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____

Parent / Guardian information

Male: ___ Female: ___

Name: _____ Date of Birth: _____

Place of employment/ school: _____

Work number: (____) _____ ext _____ Cell: (____) _____

E-Mail Address: _____

If different than child's;

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____

Emergency Contact (other than parent)

1) Name: _____ Relationship to child: _____

Home phone: (____) _____ Work phone: (____) _____

2) Name: _____ Relationship to child: _____

Home phone: (____) _____ Work phone: (____) _____

**Rhode Island Department of Health
Immunization Program**

Pre-screen form for pre-school/day care and kindergarten records

Please complete the following and attach to the child's record:

1. Child's Name _____
2. Date of Birth _____
3. Gender __M __F
4. Ethnicity __Hispanic __Non-Hispanic
5. Race __White __Black/African American __Asian
 __American Indian / Alaskan Native
 __Other (specify) _____
6. Place of Birth USA: __yes __no Rhode Island: __yes __no
7. Lead screening __yes __no
8. Date of last physical _____
9. Height _____ Date taken if different than # 8 _____
10. Weight _____ Date taken if different than # 8 _____

All information is confidential and is reported only in aggregate, with no identifying information about any individual child.

School Name & Address:



Health Care Provider Name and Address:

**STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM**

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS					
Please enter dates in MM/DD/YYYY format					
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella	<input type="checkbox"/> Student has history of varicella disease				
Tetanus-Diphtheria-Pertussis TdaP/Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: Medical Religious

Hep B DTaP PCV Polio Hib MMR Varicella Td/Tdap Rotavirus Hep A Mening HPV

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height _____ Weight _____ BP _____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No Yes DIABETES: No Yes OTHER: _____

Significant Systems Findings: _____

ALLERGIES: No Yes (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No Yes

Treatment Plan: _____

MEDICATION (REQUIRED AT SCHOOL): No Yes (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

RESTRICTIONS: Can participate in physical education: Fully With limitation _____

Can participate in sports: Fully With limitation _____

LEAD SCREENING (Required for children < 6 years of age only) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed screening <input type="checkbox"/> Screened and referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened Screening Date: _____ Comprehensive Exam Date: _____
TUBERCULOSIS (If required by school district) Date of TB test: _____		

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

*All applications are updated annually. Parents must **immediately** notify the site and MacColl YMCA of any changes on the child's information sheet, and on the pick-up list.*

**MACCOLL YMCA
PICK UP LIST**

Child's name: _____

Home phone: (____) _____

Please fill out the following information for parents/ guardians who are **ALLOWED** to pick up the child:

Mother's name: _____

Work phone: (____) _____ Cell/Other: (____) _____

Father's name: _____

Work phone: (____) _____ Cell/Other: (____) _____

List the names and addresses of individuals **ALLOWED** to pick up your child from the MacColl YMCA program sites.

NAME	ADDRESS	RELATIONSHIP	PHONE
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

List the names and addresses of individuals **NOT ALLOWED** to pick up your child from the MacColl YMCA program sites.

(Please attach a copy of any custody or restraining orders in effect.)

NAME	ADDRESS	RELATIONSHIP	PHONE
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**MACCOLL YMCA
AGREEMENT OF SERVICES**

I/ We will pick up _____ by 5:45pm.

I/We recognize that we will be charged a late fee if child is picked up after 6:00pm. _____ **(parent initials required)**

I/ We understand we must call the child care site if our child is to be absent on any given day. _____ **(parent initials required)**

I/ We give permission to photograph and display pictures of our child. _____ parent initials. (If you do not want your child's picture taken and displayed, **do not** initial this line.)

I/ We understand any child whose behavior is consistently disruptive to the smooth and safe operation of the child care program may be dismissed from the program, after sufficient warnings to the child and the parents to change this behavior. _____ **(parent initials required)**

Corporate/ Subsidized child care for my child is as follows:

_____ **DHS/ Pathways** certificate # _____

_____ **Financial Aid**

_____ **Corporate/Other (please specify)** _____

Written verification for any of the above subsidized child care must be approved and on file before the child begins in our program.

I/We understand the above information and agree to abide by the rules and regulations set forth by the MacColl YMCA.

X _____
Parent/ Guardian's Signature _____ **Date**

Special Care Plan

This must be filled out for any child with a medical concern/ condition or allergy listed on the previous page

Child's Name _____ DOB _____

Parent(s) or Guardian(s) Name _____

Primary Physician _____ phone _____

Secondary Physician (if applicable) _____ phone _____

Medication(s)

Reason special care plan is needed (allergy or medical concern)

Known Triggers:

Activities that may need special attention:

Typical signs and symptoms:

Parent or Guardian Signature

date

Special Care Plan Coordinator

date

A copy will be returned to you once signed by our special care plan coordinator

MacColl YMCA
School Cancellation, Early Release, & Delay Policy
*******Keep for your Refrigerator*******

What to do if...

School's Cancelled:

- Watch Channel 10 or Channel 12 for delay/closure announcement for the Y
- Use the Internet and go to ribroadcasters.com or turnto10.com or wpri.com for delay/closure announcement for the Y
- Get a Twitter up date at www.twitter.com/MacCollYMCA
- Call MacColl at 725-0773 after 6:30am to check on opening time

School's Delayed in Lincoln/North Providence:

- All sites will open at normal time 6:30 at MacColl, 7:00am at Saylesville, and Northern

School's Delayed in Cumberland:

- All sites will have a delayed start time (same delay time as school) example school is delayed one hour sites will open at 8:00am instead of the normal 7:00am opening time

Schools Cancel Afterschool Activities:

- All Y programs will run as normal, but we ask that parents do their best to arrive as early as possible for the safety of their children, themselves and our staff

School is Dismissed Early:

- There will be NO Y after school program
- Children must follow their designated plan to either take the school bus home or parent will pick up
- The Y will attempt to call all parents in this situation
- We encourage any parents of Kindergarten or preschool to pick up as early as possible for the safety of their child, themselves and our staff

Note to Self: My child will take Bus # _____ home or I will pick my child up from school and I need to call the school to let them know what my child's plan is.

Please complete the attached form with your child's Early School Dismissal Plan and return with the packet.

Early School Dismissal Plan

Child's Name: _____ Grade: _____

School Attending: _____

Please check off one of the following:

_____ My child will take Bus # _____ home from school

_____ I will pick my child up from school.

Office Use
Unit ID # _____

**YMCA of Pawtucket, Inc.
MACCOLL YMCA BRANCH**



Child Care Weekly Payment Agreement

I/We agree to pay the weekly fee of \$ _____ by Friday prior to the week services are offered. I/We understand the full week fee is due whether or not our child _____ participates in the program all week.

(print child's full name)

I/We receive child care subsidy from _____
My co-payment is \$ _____ per week.

Express Payment Plan

I/We wish to participate in one of the *Express Payment Plans* (choose only one):

** _____ **Bank Draft** (weekly draft from checking or savings account) **VOIDED CHECK NEEDED**
Option I

PRINT NAME ON THE ACCOUNT

NAME OF BANK	Checking	Savings
	(Circle One)	

9 DIGIT ROUTING NUMBER	7-10 DIGIT ACCOUNT NUMBER or SAVINGS #
------------------------	--

AUTHORIZED SIGNATURE	DATE
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** _____ **Credit Card** (weekly charge to credit card) or Debit Card (weekly charge to debit account)
Option II

PRINT YOUR NAME AS IT APPEARS ON CARD

CIRCLE ONE: MASTER CARD OR VISA ONLY CIRCLE ONE: CREDIT / DEBIT CARD TYPE

CREDIT CARD #	EXP DATE
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AUTHORIZED SIGNATURE	DATE
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****Please note:**

- ✘ I / We understand, I / we must submit a 2 week written notice prior to withdrawing my / our child from the childcare program I / we have registered for or my / our account will be charged the full amount.**
- ✘ I / We understand the full week's fee is due whether or not my / our child participates in the program all week.**

(Authorized Signature)



MACCOLL YMCA

HEALTH CARE POLICY

Keep for your Records

- Please use good judgment when sending your child to child care.
- Children must be able to participate in all activities.
- All allergies must be noted at time of registration.
- Any child who is sent home with a rash or fever, or wakes up with such, must remain home for 24 hr. **NO EXCEPTIONS.**

FIRST AID

- A counselor will administer First Aid to your child. All are currently certified in First-Aid and CPR. Parents will be notified, within 24 hours, or sooner when first aid has been applied.

MEDICATION

- All medication must be in the original container.
- Please hand medication in to the site director only.
- Please do not leave in lunchbox or child's backpack.
- A written note from the physician must accompany non-prescription medication. It needs to state the specific medication, and the exact dose and length of time to be given **NO EXCEPTIONS.**
- Parents need to fill out a medical release form which can be found at the parents table, for all medications
- Children with asthma may, with written parental consent, and authorization from the physician, carry their own inhalers and use them as needed. Any use of the inhaler will be documented on the child's medical log.
- Children with allergies to bee stings may carry epi-pens to be used as needed. Use will be documented on the child's medical log.
- If your child becomes ill, he/she will be separated from the group to rest quietly. We will contact a parent or emergency contact to pick up the child. Please assure that your contact numbers are accurate.

COMMUNICABLE DISEASE

- Any child who contracts a fever or rash during child care hours will be isolated from the others, and contacts will be called to pick up child immediately.
- Head Lice: are insects that feed off the human body to survive. They lie in the human scalp and are about the size of a sesame seed. Head lice hatch from eggs called nits. These tiny eggs are grayish white, and shaped like tear drops. They attach themselves to the hair shaft and are very difficult to remove. Head lice are very contagious. **The YMCA maintains a no nit policy. Children may not return to childcare until they are nit free.**

Child Fact Sheet

Please fill out the following information to help our staff get to know your child better.

Child's Full Name _____ Nickname _____

Siblings (names/ages) _____

Pets _____

Parent's occupation _____

Favorite toy to play with _____

Favorite activity _____

3 words to describe your child _____

Language(s) spoken at home _____

Preferred language for communication _____

Family traditions celebrated at home _____

What is your philosophy on discipline _____

Questions or concerns for the year _____

Any prior childcare experience (if yes, where?) _____

Any additional information that you believe would be helpful